STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure survey. This visit included the investigation of Complaint IN00113512. Complaint IN00113512: Unsubstantiated due to lack of evidence. Survey dates: August 5, 6, 7, 8. 9, and 10, 2012 Facility number: 012534 Provider number: 155792 AIM number: 201028420 Survey team: Janet Stanton, R.N.--Team Coordinator Heather Lay, R.N. (8/5, 6, 8, 9) Melanie Strycker, R.N. Census bed type: SNF--26 SNF/NF--107 Total--133 Census payor type: Medicare--30 Medicaid--61 Other--42 Total--133 Sample: 24	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed 8/15/12 Cathy Emswiller RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to report an allegation of alleged physical abuse to a resident's physician and legal representative. The deficient practice affected 1 of 2 residents	F0157	Corrective action: allegation of abuse was not substantiated at the faciity level. Physician and family have been notified. 1:1 staff education unable to be provided due to staff member no	09/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reviewed for alleged physical abuse violations in a sample of 24 residents reviewed. [Resident #201] Findings include: 1. During entrance conference on 8/6/12 at 9:30 A.M., the facility's abuse prohibition policy and procedure and 2-3 written reports of alleged abuse violations were requested from the Executive Director for completion of the "Abuse Prohibition Protocol." On 8/6/12 at 12:00 P.M.., the Executive Director provided the facility's abuse prohibition policy and procedure and the abuse investigation for Resident #201. A "Resident/Family Concern/Grievance Form" dated 4/6/12, included, but was not limited to, "Date of Concern: 4/6/12... Time of Concern: 1:00 P.M.... Date Concern Received: 4/6/12... Person receiving concern: [Social Service #8]... Nature of concern: Certified Nursing Assistant [CNA #9] working with resident [Resident #201] rough... please see attached... Concern received from: Resident [Resident #201]..." The attachment included, but was not limited to the following:		longer employed.Other residents having the potential to be affected: ED to educate all manager's on timely reportingt to ISDH of an incident/allegation/suspicion of abuse in accordance with company/state/federal guidelines, as well as, notification of physician and family. DNS/ED/designee will provide an all staff in-service 8-30-12 and during the week of 9-3-12 regarding reporting of an incident/ allegation/suspicion of abuse in accordance with company/state/federal guidelines, as well as, notification of physician and family.Systematic changes: DNS/ED/designee will provide an all staff in-service 8-30-12 and during the week of 9-3-12 regarding reporting of an incident/ allegation/suspicion of abuse in accordance with company/state/federal guidelines, as well as, notification of physician and family. ED/DNS/designee will provide a chart review within 24 hours upon each allegation of abuse to ensure family and physician notification in placeMonitoring: Results of the abuse protocol/notification questionnaire will be brought to monthly QA x 6 months then quarterly thereafter to ensure compliance.Date of compliance: 9/9/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"Resident: [Resident #201]... Date: 4/6/12 reported to Executive Director [ED] 4/9/12... Incident: Resident [Resident #201] reported that a [race] guy [CNA #9] treats him rough during care... Interviews: 4/9/12, 4/10/12... Physician [notification]: 4/9/12... Family [notification]: 4/9/12... State - Initial [notification]: 4/9/12... DON [Director of Nursing] [notification]: 4/9/12.... APS [Adult Protective Services] and Ombudsman [notification]: 4/13/12... Substantiated without findings..." The facility failed to notify Resident #201's physician and legal representative/family until 3 days after the allegation was made by the resident. On 8/9/12 at 12:15 P.M., Resident #201's closed record was reviewed. Diagnoses included, but were not limited to, bladder cancer, anemia, thrombocytopenia, and chronic airway obstruction. Resident #201 was admitted to the facility on 7/29/11 and died on 6/18/12. There was no documentation in Resident #201's clinical record regarding notification of his physician or family regarding the above allegation of physical abuse.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In an interview on 8/8/12 at 3:30 P.M., the Executive Director indicated he did not have any further documentation to provide related to the Resident #201's allegation of alleged physical abuse. He indicated he was not the Executive Director at that time. 2. The abuse policies and procedures included, but were not limited to, "Resident Abuse... The Executive Director and/or Director of Nursing will be notified... the physician will be notified and orders will be received for treatment and/or discharge based upon assessment... All abuse allegations/abuse must be reported to the Executive Director immediately, and to the resident's representative within 24 hours of the report" 3.1-5(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on observation and interview, the facility failed to post a notice of recent survey availability. The deficient practice had the potential to impact 133 of 133 residents who resided in the facility. [Residents #150, #151, #152, #153, #154, #155, #156, #157, #158, #159, and #160] Findings include: On 8/5/12 at 3:30 P.M., during initial tour of the facility, there was no notification observed related to where to locate recent survey results. The resident group interview was held on 8/7/12 at 9:30 A.M. Eleven residents, previously identified by licensed nurse unit managers as alert and oriented, and selected by the facility to attend the meeting, were in attendance. Residents #159 and #160 indicated they knew where the survey book was located, but only	F0167	Corrective actions: A temporary sign was posted in the front lobby informing visitors where the survey results were locatedOther residents having the potential to be affected: All residents have the potential to be affected. A picture frame was purchasd and placed at the receptionist desk informing visitors where the survey results are located. The location of the sign is monitored daily by the receptionist.Systematic changes: The receptionist or designee will check to see if the frame and ISDH survey results are in the proper location daily (unless otherwsde instructed due to holidays). A daily calendar will be implemented to check off placement of the posting and survey results. ED will ensure all survey results are placed in the survey binder.Monitoring: The ED or designee will monitor the posting and survey results weekly to ensure compliance. Compliance of the posting and	09/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	because they had been in the lobby and had seen it. They had not seen any posted notices that had information about where to find the survey book. Residents #150, #151, #152, #153, #154, #155, #156, #157, and #158 indicated they did not know where the survey book was located, and had not seen any signs informing them of the location. On 8/8/12 at 9:30 A.M., in an interview with Office Staff #18, she indicated the facility did not have a notice regarding where the survey results were located. She indicated the survey results were located in the front lobby on a table. 3.1-3(b)(1)		survey results will be brought to monthly QA x 6 months. Non-compliance will be addressed immediately with ongoing items reported to monthly QA.Date of completion: 9-9-12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the	F0225	Corrective actions: 1:1 education	09/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility failed to report an allegation of alleged physical abuse immediately to the facility Administrator, Director of Nursing, or Nurse Supervisor, and to State Agencies. The deficient practice affected 1 of 2 residents reviewed for alleged physical abuse violations from a sample of 24 residents reviewed. [Resident #201] Findings include: During entrance conference on 8/6/12 at 9:30 A.M., the facility's abuse prohibition policy and procedure and 2-3 written reports of alleged abuse violations were requested from the Executive Director for completion of the "Abuse Prohibition Protocol." On 8/6/12 at 12:00 P.M.., the Executive Director provided the facility's abuse investigation for Resident #201. A "Resident/Family Concern/Grievance Form" dated 4/6/12, included, but was not limited to, "Date of Concern: 4/6/12... Time of Concern: 1:00 P.M.... Date Concern Received: 4/6/12... Person receiving concern: [Social Service #8]... Nature of concern: Certified Nursing Assistant [CNA #9] working with resident [Resident #201] rough... please see attached... Concern received from:		cannot be provided due to the staff member no longer employed. All allegations of abuse will be investigated per policy and procedure and reported to state agencies per policy.Other residents having the potential to be affected: All residents have the potential to be affected. ED to educate all manager's (8-31-12) on immediate reporting to the facility Administrator, Director of Nursing or Nurse Supervisor upon the occurrence of an incident/allegation/suspicion of abuse in accordance with company/state/federal guidelines, as well as, notification of physician and family. An all staff in-service will also be provided (8-31-12 and during the week of 9-3-12) regarding reporting of an incident/ allegation/suspicion of abuse to the Administrator, Director of Nurses or Nurse Supervisor in accordance with company/state/federal guidelines. Systematic changes: ED to educate all manager's (8-31-12) on immediate reporting to the facility Administrator, Director of Nursing or Nurse Supervisor upon the occurrence of an incident/allegation/suspicion of abuse in accordance with company/state/federal guidelines, as well as, notification of physician and family. An all staff in-service will also be provided (8-31-12 and during the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident [Resident #201]..." The attachment included, but was not limited to the following: "Resident: [Resident #201]... Date: 4/6/12 reported to Executive Director [ED] 4/9/12... Incident: Resident [Resident #201] reported that a [race] guy [CNA #9] treats him rough during care... Interviews: 4/9/12, 4/10/12... Physician [notification]: 4/9/12... Family [notification]: 4/9/12... State - Initial [notification]: 4/9/12... DON [Director of Nursing] [notification]: 4/9/12.... APS [Adult Protective Services] and Ombudsman [notification]: 4/13/12... Substantiated without findings..." The investigation included, but was not limited to, "Facility Reporting Incident Form: Incident Date: 4/6/12... Incident Time: 1:00 P.M.... Residents Involved: [Resident #201]... Staff Involved: [CNA #9]... Brief Description of Incident: Resident [Resident #201] reported to the Social Service Director [SS #9] that a black guy [CNA #9] treats him rough during care... Immediate Action Taken: Investigation began [on 4/9/12]... Once the Executive Director [ED] figured out who the CNA was he [CNA #9] was suspended... Resident [Resident #201] was interviewed (Brief Interview Mental		week of 9-3-12) regarding reporting of an incident/ allegation/suspicion of abuse to the Administrator, Director of Nurses or Nurse Supervisor in accordance with company/state/federal guidelines. ED/DNS/designee will review/investigate all abuse allegations and report to the mandated agencies upon each occurrence.Monitoring: Results of the abuse protocol/notification questionnaire will be brought to monthly QA x 6 months then quarterly thereafter to ensure compliance.Date of completion 9-9-12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Status of 7 [cognitive impairment]) with a witness present... Resident [Resident #201] was not able to repeat the information shared with the Social Service Director [SS #8]... Per the investigation the resident does not feel abused in any way... Employee [CNA #9] was interviewed. Resident's physician and family were notified [on 4/9/12]... Residents under the assignment of the CNA [#9] have been interviewed by the second Social Worker and there are no concerns reported... Staff have been re-educated on timely abuse awareness/reporting to the Administrator... The Social Service Director who received the resident complaint was suspended per policy for failure to report to the Administrator timely... Follow-up: The CNA [#9] returned to work since there were no concerns substantiated... Preventive measures taken: Residents will continue to be educated on abuse awareness and reporting upon admission and via resident council..." In an interview on 8/8/12 at 3:30 P.M., the Executive Director indicated he did not have any further documentation to provide related to the Resident #201's allegation of alleged physical abuse. He indicated he was not the Executive Director at that time.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 8/9/12 at 12:15 P.M., Resident #201's closed record was reviewed. Diagnoses included, but were not limited to, bladder cancer, anemia, thrombocytopenia, and chronic airway obstruction. Resident #201 was admitted to the facility on 7/29/11 and died on 6/18/12. There was no documentation in Resident #201's clinical record regarding injury related to the above allegation of physical abuse. 3.1-28(c)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure their Abuse Prohibition Policies were followed related to reporting alleged physical abuse to the Administrator, Director of Nursing, or Supervisor, and State agencies. The deficient practice affected 1 of 2 residents reviewed for alleged physical abuse violations in a sample of 24 residents reviewed. [Resident #201] Findings include: 1. During entrance conference on 8/6/12 at 9:30 A.M., the facility's abuse prohibition policy and procedure and 2-3 written reports of alleged abuse violations were requested from the Executive Director for completion of the "Abuse Prohibition Protocol." On 8/6/12 at 12:00 P.M.., the Executive Director provided the facility's abuse prohibition policy and procedures and the abuse investigation for Resident #201. A "Resident/Family Concern/Grievance	F0226	Corrective actions: 1:1 education cannot be provided due to the staff member no longer employed. All allegations of abuse will be investigated per policy and procedure and reported to state agencies per policy.Other residents having the potential to be affected: All residents have the potential to be affected. ED to educate all manager's (8-31-12) on immediate reporting to the facility Administrator, Director of Nursing or Nurse Supervisor upon the occurrence of an incident/allegation/suspicion of abuse in accordance with company/state/federal guidelines, as well as, notification of physician and family. An all staff in-service will also be provided (8-31-12 and during the week of 9-3-12) regarding reporting of an incident/ allegation/suspicion of abuse to the Administrator, Director of Nurses or Nurse Supervisor in accordance with company/state/federal guidelines. Systematic changes: ED to educate all manager's (8-31-12) on immediate reporting to the facility Administrator, Director of	09/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Form" dated 4/6/12, included, but was not limited to, "Date of Concern: 4/6/12... Time of Concern: 1:00 P.M.... Date Concern Received: 4/6/12... Person receiving concern: [Social Service #8]... Nature of concern: Certified Nursing Assistant [CNA #9] working with resident [Resident #201] rough... please see attached... Concern received from: Resident [Resident #201]..." The attachment included, but was not limited to the following: "Resident: [Resident #201]... Date: 4/6/12 reported to Executive Director [ED] 4/9/12... Incident: Resident [Resident #201] reported that a [race] guy [CNA #9] treats him rough during care... Interviews: 4/9/12, 4/10/12... Physician [notification]: 4/9/12... Family [notification]: 4/9/12... State - Initial [notification]: 4/9/12... DON [Director of Nursing] [notification]: 4/9/12.... APS [Adult Protective Services] and Ombudsman [notification]: 4/13/12... Substantiated without findings..." The investigation included, but was not limited to, "Facility Reporting Incident Form: Incident Date: 4/6/12... Incident Time: 1:00 P.M.... Residents Involved: [Resident #201]... Staff Involved: [CNA #9]... Brief Description of Incident:		Nursing or Nurse Supervisor upon the occurrence of an incident/allegation/suspicion of abuse in accordance with company/state/federal guidelines, as well as, notification of physician and family. An all staff in-service will also be provided (8-31-12 and during the week of 9-3-12) regarding reporting of an incident/ allegation/suspicion of abuse to the Administrator, Director of Nurses or Nurse Supervisor in accordance with company/state/federal guidelines. ED/DNS/designee will review/investigate all abuse allegations and report to the mandated agencies upon each occurrence.Monitoring: Results of the abuse protocol/notification questionnaire will be brought to monthly QA x 6 months then quarterly thereafter to ensure compliance.Date of completion 9-9-12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident [Resident #201] reported to the Social Service Director [SS #9] that a black guy [CNA #9] treats him rough during care... Immediate Action Taken: Investigation began [on 4/9/12]... Once the Executive Director [ED] figured out who the CNA was he [CNA #9] was suspended... Resident [Resident #201] was interviewed (Brief Interview Mental Status of 7 [cognitive impairment]) with a witness present... Resident [Resident #201] was not able to repeat the information shared with the Social Service Director [SS #8]... Per the investigation the resident does not feel abused in any way... Employee [CNA #9] was interviewed. Resident's physician and family were notified [on 4/9/12]... Residents under the assignment of the CNA [#9] have been interviewed by the second Social Worker and there are no concerns reported... Staff have been re-educated on timely abuse awareness/reporting to the Administrator... The Social Service Director who received the resident complaint was suspended per policy for failure to report to the Administrator timely... Follow-up: The CNA [#9] returned to work since there were no concerns substantiated... Preventive measures taken: Residents will continue to be educated on abuse awareness and reporting upon admission and via resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	council..." In an interview on 8/8/12 at 3:30 P.M., the Executive Director indicated he did not have any further documentation to provide related to the Resident #201's allegation of alleged physical abuse. He indicated he was not the Executive Director at that time. 2. The abuse policies and procedures included, but were not limited to, "Physical Abuse: includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment... All abuse allegations/abuse must be reported to the Executive Director immediately, and to the resident's representative within 24 hours of the report... Failure to report will result in disciplinary action, up to and including immediate termination... The Executive Director/designee will report all unusual occurrences, which include abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health..." 3.1-28(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to maintain sharp utensils in a secure manner, on 1 of 1 locked/Alzheimer's unit. This deficiency had the potential to impact 34 of 34 residents currently residing on that unit. Findings include: On 8/9/12 at 9:30 A.M., environmental tour of the facility was initiated with the Maintenance Supervisor. On 8/9/12 at 9:45 A.M., during tour of the facility locked dementia unit, a large steak knife was observed in an unlocked drawer in the kitchen area. At that time, in an interview, Activities Assistant #2 indicated the drawer was usually unlocked because it did not contain any knives. On 8/9/12 at 9:45 A.M., the Maintenance Supervisor removed the knife and locked the drawer.	F0323	Corrective action: the knife was removed and all other areas accessible to the residents were assessed for sharp utensils. No other objects were identified.Other residents having the potential to be affected: All residents residing on the Memory Care Unit have the potential to be affected. All drawers were inspected for appropriate locking mechanisms to ensure in working order. Areas accessible to residents have been identified and locks have been placed on the drawers/cabinets that have the capability of storing sharp utensils to ensure they are secured. Activity storage area has been assessed for sharp objects. Locks applied as applicable.Systematic changes: Memory Care Facilitator (MCF) or designee will provide rounds following each meal(daily) to ensure no sharp objects remain out in the open and accessible to residents (this will be ongoing). MCF will provide an in-service to the staff who works on the Unit regarding maintaining a resident environment that remains free of accidents/hazards and to check accessible areas	09/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During that time, residents were observed in the kitchen area doing various activities. On 8/9/12 at 3:30 P.M., the policy and procedure on storage of sharp objects in the locked dementia unit was requested from the Executive Director. The facility did not provide a policy and procedure for storage of sharp objects in the locked dementia unit. 3.1-45(a)(1)		following each meal for sharp objects/potential hazards on 8-30-12 and during the week of 9-3-12.Monitoring: The MCF or Executive Director (ED) will monitor the daily checks weekly x 6 months to ensure that no sharp objects or potential hazards are accessible to residents. Results of the monitoring will be brought to monthly QA x 6 months then quarterly thereafter unless otherwise determined by the IDT/QA team. If noncompliance is <95%, an action plan will be developed.Date of completion: 9-9-12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, record review, and interview, the facility failed to post daily nurse staffing. The deficient practice had the potential to impact 133 of 133 residents who resided in the facility.	F0356	Corrective action: daily nurse staffing was removed from the binder and placed in a picture frame in an area accessible to residents.Other residents having the potential to be affected: All residents have the potential to be	09/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: On 8/6/12 at 10:00 A.M., during initial tour of the facility, a binder labeled, "Nursing Staff Report" was observed on a table near the nurse's station, and was reviewed at that time. The "Nursing Staff Report" binder had a "Nursing Staff Report" for 8/3 and 8/6/12. On 8/8/12 at 9:30 A.M., during environmental tour, the Maintenance Supervisor indicated the staffing was usually displayed out of the binder and displayed for each day. 3.1-14(i)(4)		affected. Daily nurse staffing was removed from the binder and placed in a picture frame in an area accessible to residents. The new staffing coordinator (or designee) will be responsible for posting the nurse staffing on a daily basis so that it is accessible to residents and visitors.Systematic changes: daily nurse staffing was removed from the binder and placed in a picture frame in an area accessible to residents and visitors. The new staffing coordinator (or designee) will be responsible for posting the nurse staffing on a daily basis so that it is accessible to residents and visitors. Director of Nursing Services (DNS) will educate nurses leadership team on the posting requirement to assist in monitoring of the daily staffing hours during the week of 9-27-12.Monitoring: Staffing Coordinator, ED, DNS or designee will visually monitor the daily staffing hours on a daily basis, ongoing. Date of completion: 9-9-12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to properly store and handle food in 1 of 1 kitchen, and 1 of 2 kitchenettes. This deficient practice had the potential to affect 132 of 133 residents who consumed food prepared in the facility kitchen. Findings include: 1. On 8/5/12 at 4:10 P.M., initial tour of the kitchen was initiated with Cook #3. During that time, the following was observed in the refrigerator: A. 1 large metal pan of mixed salad without covering or label. B. 1 large bottle of white liquid [ranch dressing] without a label. C. 1 bag of ready to eat salad mix that was open to air without an open date. D. 1 large container of brown thick liquid [pudding] without a label.	F0371	Corrective action: identified food was covered, labeled and dated as required. The liver was thrown out. Hairnets were placed accordingly on staff.Other residents having the potential to be affected: All residents have the potential to be affected. All food items in the kitchen were reviewed to ensure that items are covered, labeled and dated as required. Boxes of hairnets have been placed by each entrance into the kitchen to ensure all staff wears hairnets as appropriate. Frozen meat will be placed in the refrigerator for proper thawing according to dietary guidelines/policies and procedures.Systematic changes: A new Certified Dietary Manager (CDM) has been hired. The RD will educate the dietary staff on the following on 8-31-12: food safety, food storage, preparation of handling of food and dietary personal hygiene/infection control (the CDM will provide additional in-servicing to the dietary staff during the week of 9-3-12 on the same education)Monitoring: The CDM/designee will provide daily rounds following each meal to	09/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	E. 1 medium container of thin brown liquid [chocolate sauce] without a label. The following was observed in the dry storage area: F. 1 plastic bag of "Resource Thicken Up" that was open to air without an open date. G. 1 five pound container of "Creamy Peanut Butter" without an open date. The following was observed in the walk-in refrigerator: H. 1 pitcher of light brown liquid [apple juice] without a label. I. 1 large container of pink liquid without a label. J. 1 large container of orange liquid [orange juice] without a secure lid or label. K. 4 trays of raw bacon open to air without a label. L. 1 box of frozen liver [placed in refrigerator for thawing] sitting directly on top of thawed hamburger.		ensure food is covered, dated and labeled, and that the appropriate hair nets are worn by all dietary personnel. The CDM/designee will monitor food that is being thawed appropriately per policy and procedure upon each occurrence daily - ongoing. If non-compliance is <95%, an action plan will be developed.Date of completion: 9-9-12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The following was observed in a sink near the preparation area of the kitchen: M. A large container of meat [liver] floating in red-tinged liquid was observed in the sink. 2. On 8/5/12 at 4:17 P.M., in an interview, Cook #3 indicated she had placed the liver to thaw in the sink around 2:00 P.M. to thaw. She indicated the liver was going to be prepared for the next evening meal and she was getting it thawed for the next day. On 8/5/12 at 4:27 P.M., the Dietary Manager arrived for tour of the kitchen. At that time, in an interview, the Dietary Manager indicated thawing meat in a sink at room temperature was not the correct method and the facility would not be serving the liver that was thawed in the sink. 3. On 8/5/12 from 4:45 P.M. through 5:50 P.M.., meal service was observed in the 100 hall dining area. At that time, Dietary Aide #4 was observed serving food on individual plates without a hairnet. 4. On 8/8/12 from 12:37 P.M. through			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1:35 P.M., meal service was observed in the facility's main dining room. At that time, Dietary Aides #6, #7, and #8 were observed serving food that was not covered without properly placed hairnets. Each dietary aide had the hair on their foreheads uncovered. 5. During the lunch meal on 8/7/12 at 12:35 P.M., Dietary Aide #5 was observed to have a white hair net covering her hair from the mid-crown area to the back of her head. The front half of her head, from the mid-crown to forehead, was uncovered, and she had long bangs hanging down to her eyes. She was observed to carry uncovered plates of food and uncovered glasses of drinks from the service window to the residents at the tables throughout the meal service. 6. During the lunch meal on 8/7/12 at 1:15 P.M., a 3-tier cart was observed in the secured/locked Alzheimer's unit, near the kitchenette area. The top tier had 7 pitchers--2 with a red juice, 2 with a yellow juice, 1 with a clear liquid, and 2 empty. None of the pitchers were labeled to identify the contents, and there was no date the liquids had been prepared, or by what date they were to be used.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During the lunch meal on 8/8/12 at 1:05 P.M., a 3-tier cart was again observed in the secured/locked Alzheimer's unit near the kitchenette. There were 7 unlabeled, undated pitchers on the cart. Two pitchers contained a yellow liquid, 2 had a red liquid, 2 had a clear liquid, and 1 was empty. 7. On 8/6/12 at 12:30 P.M.., the Registered Dietician provided the facility policy and procedure for "Food Storage" dated 7/11 and "Dietary Personal Hygiene" dated 2/07. The "Food Storage" policy and procedure included, but was not limited to, "Containers with tight fitting covers must be used for storing... all containers must be labeled appropriately... Leftover prepared foods are to be stored in covered containers or wrapped securely... the food must be clearly labeled with the name of the product, the date it was prepared and marked to indicate the date by which the food shall be consumed or discarded... Cooked foods must be stored above raw foods to prevent contamination... All foods should be covered, labeled, and dated... Frozen meat, poultry, and fish should be defrosted in a refrigerator for 24-48 hours... Frozen items may also be thawed under cool running water or as part of the cooking process and should be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	used immediately after thawing..." The "Dietary Personal Hygiene" policy and procedure included, but was not limited to, "Personal Cleanliness... Wear a clean hat or other hair restraint..." 3.1-21(i)(2) 3.1-21(i)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to properly label resident medications. This deficient practice impacted 3 of 133	F0431	Corrective action: identified drugs were removed and all other medications were reviewed for proper labeling and expiration dates.Other residents having the	09/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents whose medications are stored by the facility. [Residents #65, #18, and #7] Findings include: 1. On 8/6/12 at 10:15 A.M., tour of the medication room was initiated with Registered Nurse [RN] #1. The following liquid medications were observed open, without an open or expiration date: Resident #65: Gabapentin 250 milligrams per 5 milliliters. Resident #18: Lisinopril 1 milligram per milliliter, Certa-Vite, and Nystatin, 100,000 suspension. Resident #7: Vancomycin 250 milligrams per 10 milliliters. 2. On 8/6/12 at 10:25 A.M., in an interview, RN #1 indicated all medications were to be labeled with an expiration date of open date when first opened or used. At that time, RN #1 indicated she was unable to find an expiration date or open date on any of the above medications. 3. On 8/9/12 at 11:30 A.M., the facility policy and procedure for "Label		potential to be affected: All residents have the potential to be affected. A 100% audit was completed of all med rooms and med carts to ensure medications were properly labeled and had and identified open and/or expiration date. Systematic changes: DNS educated the licensed nurses on medication storage and labeling. Unit Managers will be responsible for checking med rooms daily x 30 days, 3x/week x 4 weeks then weekly ongoing. Will utilize pharmacy consult to provide additional pharmacy review on a monthly basis ongoing.Monitoring: DNS or designee will monitor the weekly med room audits on an ongoing basis. DNS or designee will monitor the monthly pharmacy consult report on an ongoing basis. Results of the audit will be brought to monthly QA on an ongoing basis.Date of completion 9-9-12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Expiration Dates and Manufacturer's Expiration Dates" no date, was received from the Director of Nursing [DoN]. The policy and procedure included, but was not limited to, "Purpose: To ensure that labeling of medications are in accordance with Federal and State labeling requirements and accepted standards of practice... Expiration Dates: Medication must be checked regularly for expiration dates and deterioration..." 3.1-25(j) 3.1-25(k) 3.1-25(l)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on record review and interview, the facility failed to ensure that 2-step testing	F0441	Corrective action: An audit was completed to determine what	09/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for tuberculosis (TB) was completed within 3 months prior to admission or upon admission to the facility. This deficient practice affected 9 residents in a sample of 24 residents reviewed. (Residents #35, #46, #53, #59, #67, #78, #117, and #202.) Findings include: 1. The clinical record of Resident #46 was reviewed on 8/7/12, at 9:30 A.M. Resident #46 was admitted to the facility on 12/22/11. Diagnoses included, but were not limited to, dementia, hypertension, asthma, and history of hypoxemia. A TB skin test was administered on 12/22/11 and was read on 12/25/11. There was no documentation that a second step TB test was administered within 1-3 weeks later. 2. The clinical record of Resident #117 was reviewed on 8/8/12, at 1:20 P.M. Resident #117 was admitted to the facility on 6/19/12. Diagnoses included, but were not limited to, post-operative paraplegia after resection of T4-T6, ependymoma, and alteration of sensations. A TB skin test was administered on 6/21/12, two days after admission, and was read on 6/23/12. There was no documentation that a second step TB test was administered within 1-3 weeks later.		residents needed a 1st/2nd step ppd. PPD's have been administered to identified residents and a tb screening questionnaire has been completed for resident 35.Other residents having the potential to be affected: All residents have the potential to be affected. Following the audit, ppd's will be administered to affected residents as appropriate. 1st step ppd's will be administered upon admission with 2nd step to be completed no earlier than 10 days or no longer than 21 days from the 1st step ppd, then annually thereafter.Systematic changes: The Staffing Development Coordinator (SDC) will implement and utilize a ppd tracking log to ensure all ppd's are administered per policy and procedure in according with state/federal guidelines. Education will be provided to licensed nursing personnel (8-30-12 and during week of 9-3-12) regarding infection control procedures as it pertains to 1st and 2nd step ppd's policy and procedures.Monitoring: The ppd tracking log will be reviewed by the DNS or designee monthly on an ongoing basis. Infection Control will be reviewed during monthly QA on an ongoing basis.Date of completion: 9-9-12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3. The clinical record of Resident #67 was reviewed on 8/'8/12, at 2:25 P.M. Resident #67 was admitted to the facility on 7/27/11. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), anemia, hypertension, and atrial fibrillation. A TB skin test administered 7/28/11, the day after admission, and was read on 7/31/11. There was no documentation that a TB skin test had been completed for 2012. 4. The clinical record of Resident #35 was reviewed on 8/9/12, at 10:25 A.M. Resident #35 was admitted to the facility on 10/23/11. Diagnoses included, but were not limited to, dementia, type II diabetes, hypertension, and ischemic heart disease. The clinical record of Resident #35 indicated this resident has a history of a significant reaction to a TB skin test. There was no documentation that a TB screening questionnaire was completed for this resident prior to or upon admission. 5. The clinical record of Resident #53 was reviewed on 8/9/12, at 11:00 A.M. Resident #53 was admitted to the facility on 6/12/12. Diagnoses included, but were not limited to, spinal compression fracture, advanced Parkinson's disease, type II diabetes, chronic kidney disease,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hypertension, and weight loss. A TB skin test was administered on 6/12/12, and was read on 6/15/12. There was no documentation that a 2nd step TB skin test was administered within 1-3 weeks later. 6. The clinical record of Resident #59 was reviewed on 8/9/12, at 12:45 P.M. Resident #59 was admitted to the facility on 12/22/11. Diagnoses included, but were not limited to, dementia, Parkinson's disease, congestive heart failure, history of chest congestion, and pneumonia. A TB skin test was administered on 12/22/11, and was read on 12/25/11. There was no documentation that a 2nd step TB skin test was administered within 1-3 weeks later. 7. At daily conference on 8/9/11, at 4:15 P.M., the Director of Nursing was given the opportunity to provide any additional documentation of TB skin tests for Residents #22, #35, #46, #53, #59, #67, #78, #117, and #202. At 9:30 A.M., on 8/10/11, Assistant Director of Nursing (ADON) provided copies of the information requested at daily conference on 8/9/11, and stated, "If it isn't here, we don't have it, and there were some things we didn't have." Stapled to the Medication Administration			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Record (MAR) for Resident #117 was a handwritten note that indicated, "[Name of Resident #117] did not get 2nd step." 8. On 8/9/12 at 1:00 P.M., Resident #202's closed record was reviewed. Diagnoses included, but were not limited to, hypertension, prostate cancer, and dementia. Resident #202 was admitted to the facility on 6/11/12 and discharged to a different facility on 6/16/12. A "Medication Administration Record" dated 6/11/12 through 6/30/12, included, but was not limited to, "May have 1st Step PPD [tuberculin skin test]... date documented as given was 6/12/12..." There was no documentation of the tuberculin skin test being read. Further, there was no documentation in the clinical record regarding any signs or symptoms of respiratory illness. On 8/9/12 at 3:30 P.M., Resident #202's admission tuberculin skin testing was requested from the Executive Director. The Executive Director and Director of Nursing were unable to provide further documentation related to Resident #202's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	admission tuberculin skin testing upon exit. 9. The clinical record for Resident #78 was reviewed on 8/7/12 at 1:25 P.M. The resident was admitted on 2/6/12 with diagnoses that included, but were not limited to, diabetes, hypertension, osteoarthritis, and dementia. A P.P.D. [Purified Protein Derivative] tuberculin skin test for tuberculosis was administered upon admission on 2/6/12. The date the test was read in 48 to 72 hours was not documented. Another P.P.D. test was administered on 2/10/12 and was documented as read on 2/12/12. A third test was administered on 2/26/12 and documented as read on 2/28/12. During the daily conference on 8/9/12 at 4:15 P.M., the Director of Nursing was given the opportunity to submit any evidence that a 1st. step P.P.D. test was completed at the time of admission. In an interview on 8/10/12 at 10:00 A.M., the Assistant Director of Nursing indicated if the information was not provided with other paperwork, then they			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	didn't have anything else. At the final exit on 8/10/12 at 3:40 P.M., no additional information was provided to demonstrate the P.P.D. test was completed upon admission. 3.1-18(e) 3.1-18(f)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. A. Based on interview and record review, the facility failed to document the specific criteria used, a summary of information collected, and the decision-making process, to demonstrate that residents were appropriately admitted to the facility Dementia/Alzheimer's secured/locked unit. This deficiency impacted 6 of 7 residents reviewed who were admitted directly to that unit; in a sample of 24 residents reviewed. [Residents #78, #80, #81, #90, #99, and #101] B. Based on interview and record review, the facility failed to document assessments of the bruit [sound heard by stethoscope] /thrill [vibration felt by touch] of a dialysis fistula access site, for 1 of 2 dialysis residents reviewed who received hemodialysis through a shunt or	F0514	Corrective action: A policy and procedure regarding pre-admission criteria for Auguste's Cottage has been developed and will be implemented. The policy was reviewed and education was given on dialysis care including bruit/thrill to nursing personnel. Moving forward, weights obtained for resident 41 as ordered.Other residents having the potential to be affected: All residents residing on Auguste's Cottage will be reviewed for placement on Auguste's Cottage according to the updated pre-admission policy and procedure. All residents receiving dialysis will be assessed for bruit and thrill per physician order. A 100% audit for residents receiving daily weights will be completed to ensure orders in place and residents on a daily weight	09/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	fistula site; in a sample of 24 residents. [Resident #22] C. Based on interview and record review, the facility failed to document daily weights as ordered by the physician, for 1 of 1 resident who had orders for a daily weight; in a sample of 24 residents reviewed. [Resident #41] Findings include: A.1. The clinical record for Resident #78 was reviewed on 8/7/12 at 1:25 P.M. The resident was admitted from home directly to the secured/locked Alzheimer's unit on 2/6/12, with diagnoses that included, but were not limited to, diabetes, depression, and dementia. Documentation of a comprehensive assessment, which included information about the resident gathered prior to the admission, and the process used to determine if he was appropriate to live on a secured/locked unit, was not found. During the daily conference on 8/8/12 at 4:15 P.M., the Administrator and Director of Nursing were given the opportunity to submit any documentation related to criteria used, information collected, and process used to determine that it was appropriate for Resident #78 to be		schedule per physician order.Systematic changes: ED will provide the IDT with education on the pre-admission screening tool for residents being admitted to Augustes's Cottage on 8-31-12. DNS/designee will educate the licensed nurses on bruit/thrill assessments and dialysis care (8-30-12 and during week of 9-3-12). Nursing staff will be educated on obtaining and documenting daily weights. Unit Manager's/designee will audit the MAR's daily x 30 days then bi-weekly thereafter ongoing to ensure daily assessment and documentation for bruit/thrill. Unit Manager's/designee will audit residents who have orders for daily weights on a daily basis x 30 days then bi-weekly thereafter.Monitoring: Unit Manager's/designee will audit the MAR's daily x 30 days then bi-weekly thereafter ongoing to ensure daily assessments and documentation for bruit/thrill. Unit Manager's/designee will audit residents who have ordes for daily weights on a daily basis x 30 days then bi-weekly thereafter. Results of the audit will be reviewed by the DNS on a weekly basis ongoing. Results of the audits will be brought to monthly QA x 6 months then quarterly thereafter.Date of completion: 9-9-12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	admitted to a secured/locked Alzheimer's unit. On 8/10/12 at 9:00 A.M., the corporate Director of Nursing Services Specialist provided a form, titled "Resident Assessment," which was completed on 1/24/12. The assessment included demographic and physical measurement information. In the section "Long-term Care vs. Memory Care vs. Rehab," the "Memory Care" was circled. The "Reason for Placement/Current Problems" section indicated "Due to diagnosis Alzheimer's, unable to manage at home, diabetic managed by p.o. [per os--"by mouth"] meds." There was no information related to the resident's need to be on a secured/locked unit. A.2. The clinical record for Resident #80 was reviewed on 8/8/12 at 1:30 P.M. The resident was admitted directly to the secured/locked Alzheimer's unit on 1/2/12, with diagnoses that included, but were not limited to, anxiety state, depressive disorder, and alcohol-induced dementia. Documentation of a comprehensive assessment, which included information about the resident gathered prior to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	admission, and the process used to determine if she was appropriate to live on a secured/locked unit, was not found. During the daily conference on 8/8/12 at 4:15 P.M., the Administrator and Director of Nursing were given the opportunity to submit any documentation related to criteria used, information collected, and process used to determine that it was appropriate for Resident #80 to be admitted to a secured/locked Alzheimer's unit. On 8/10/12 at 9:00 A.M., the corporate Director of Nursing Services Specialist provided a copy of a "Nursing/Social Work Assessment" form, dated 12/14/11, from a facility in Florida. The form indicated "... Secured Dementia unit at [name of facility]. Remain custodial care LTC [Long Term Care] at SNF [Skilled Nursing Facility]. Acclimated to secured dementia unit and staff. Wanted to move home to be closer to her family." Documentation of an assessment by Countryside Meadows demonstrating the resident's continued need to be placed in a secured/locked unit was not provided. A.3. The clinical record for Resident #81 was reviewed on 8/8/12 at 2:20 P.M. The resident was admitted directly to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	secured/locked Alzheimer's unit on 10/1/11, with diagnoses that included, but were not limited to, dementia and bi-polar disorder. Documentation of a comprehensive assessment, which included information about the resident gathered prior to the admission, and the process used to determine if she was appropriate to live on a secured/locked unit, was not found. During the daily conference on 8/8/12 at 4:15 P.M., the Administrator and Director of Nursing were given the opportunity to submit any documentation related to criteria used, information collected, and process used to determine that it was appropriate for Resident #81 to be admitted to a secured/locked Alzheimer's unit. On 8/10/12 at 9:00 A.M., the corporate Director of Nursing Services Specialist provided an "Initial Assessment" physician's progress note, dated 10/3/11. The note listed the admitting diagnoses, review of systems, and physical examination information. There was no information recommending the resident be placed on a secured/locked Alzheimer's unit. Documentation of a facility assessment			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	demonstrating the process used to determine if this resident was appropriate for placement on an Alzheimer's unit was not provided. A.4. The clinical record for Resident #90 was reviewed on 8/8/12 at 3:05 P.M. The resident was admitted from home directly to the locked/secured Alzheimer's unit on 1/25/12, with diagnoses that included, but were not limited to, uncomplicated dementia, anxiety state, and depressive disorder. Documentation of a comprehensive assessment, which included information about the resident gathered prior to the admission, and the process used to determine if she was appropriate to live on a secured/locked unit, was not found. During the daily conference on 8/8/12 at 4:15 P.M., the Administrator and Director of Nursing were given the opportunity to submit any documentation related to criteria used, information collected, and process used to determine that it was appropriate for Resident #90 to be admitted to a secured/locked Alzheimer's unit. At the final exit on 8/10/12 at 3:50 P.M., no additional documentation was provided for review.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A.5. The clinical record for Resident #99 was reviewed on 8/9/10 at 3:25 P.M. The resident was admitted from another facility's secured/locked Alzheimer's unit directly to the secured/locked Alzheimer's unit at Countryside Meadows on 9/26/11. Diagnoses included, but were not limited to, cataracts, hypertension, and vascular dementia second to an aneurysm. Documentation of a comprehensive assessment, which included information about the resident gathered prior to the admission, and the process used to determine if he was appropriate to live on a secured/locked unit, was not found. During the daily conference on 8/9/12 at 4:15 P.M., the Administrator and Director of Nursing were given the opportunity to submit any documentation related to criteria used, information collected, and process used to determine that it was appropriate for Resident #99 to be admitted to a secured/locked Alzheimer's unit. On 8/10/11 at 9:00 A.M., the Director of Nursing Services Specialist provided a form, titled "Resident Assessment," dated 9/16/11. The assessment included demographic and physical measurement information. In the section "Long-term			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Care vs. Memory Care vs. Rehab," the "Memory Care" was circled. The "Reason for Placement/Current Problems" section indicated "53 year old with vascular dementia due to had an aneurysm in 2011. Was at [name of hospital] and discharged to [another facility]. Is at home now--needs 24 hour care. Family unable to care for him long term." There was no information related to the resident's need to be on a secured/locked unit. A.6. The clinical record for Resident #101 was reviewed on 8/9/12 at 3:00 P.M. The resident was admitted directly to the secured/locked Alzheimer's unit on 9/19/11 with diagnoses that included, but were not limited to, senile dementia--Alzheimer's type, behavior disturbance, and depressive disorder. Documentation of a comprehensive assessment, which included information about the resident gathered prior to the admission, and the process used to determine if he was appropriate to live on a secured/locked unit, was not found. During the daily conference on 8/9/12 at 4:15 P.M., the Administrator and Director of Nursing were given the opportunity to submit any documentation related to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	criteria used, information collected, and process used to determine that it was appropriate for Resident #101 to be admitted to a secured/locked Alzheimer's unit. On 8/10/11 at 9:00 A.M., the Director of Nursing Services Specialist provided a form, titled "Resident Assessment," dated 9/8/11. The assessment included demographic, social, medical history, and physical measurement information. The "Current Problems/Reasons for Placement" section indicated "... male with dementia living at home with son. Patient is very pleasant, however short/long term memory impaired. Judgement limited. Patient requires 24 hour supervision. Unsafe to be home alone.... Secure environment. Recently found by neighbors walking down [not legible]...." There was no information related to the resident's need to be on a secured/locked unit. A.7. On 8/6/12 following the entrance conference at 9:00 A.M., the Executive Director provided a copy of the required "Alzheimer's/Dementia Special Care Unit" [State Form 48896] form, dated 12/15/11. The form indicated the facility had a "formal written process for:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	physician's evaluation/diagnosis, staff evaluation, psychiatric evaluation/diagnosis, family conference, appeal procedure, other...." On 8/9/12 at 9:00 A.M., the Executive Director provided a copy of the "Auguste's Cottage [the name of the facility's Dementia/Alzheimer's unit] Dementia & Alzheimer's Specialty Units Move-In, Admission and Continued Stay Criteria" packet, dated 2012. The packet included, but was not limited to, the following information: "The intent of the Auguste's cottage program is to provide a home-like environment, to those challenged with various dementia diagnoses, that maximizes dignity, productivity and quality of life. Admission to the program is not based solely upon diagnosis or disease state, but is based on a variety of criteria as dictated by the state of Indiana and American Senior Communities. The decision to accept an individual into the Auguste's Cottage program is made at the facility level and is based upon the best information gathered by an interdisciplinary team following the initial admission assessment...." The specific criteria used to determine			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	appropriate admission to the unit was not specified. In an interview on 8/10/12 at 1:30 P.M., the corporate Director of Nursing Services Specialist and the Social Service Director indicated a corporate liaison person, who was not an employee of the facility, evaluated potential residents while in the hospital. The liaison would review ADL scores, diagnoses, treatments, prior history, ambulatory status, cognitive status, goals, and elopement risk. The liaison could make a recommendation for the potential resident to be admitted to the secured/locked Alzheimer's unit at any facility in the corporation, according to geographical location. They indicated there were no written assessments that summarized all of the gathered pre- and post- admission information, and which demonstrated how the facility reached a decision to place one particular resident in the locked/secured unit as opposed to another who would not be placed in the unit. Specific criteria [such as wandering, exit-seeking, getting lost in the community, needing structured activities] to assist in making a decision to place a new resident in the locked/secured unit was not actually written down and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	available to use for determining placement. B.1. On 8/6/12 at 10::45 A.M., initial tour was initiated with Registered Nurse [RN] #13. At that time, Resident #22 was identified as interviewable and receiving dialysis on Monday, Wednesday, and Friday. RN #13 indicated Resident #22 was not on a fluid restriction. On 8/9/12 at 11:05 A.M., Resident #22's record was reviewed. Diagnoses included, but were not limited to, end stage renal disease, hypertension, and dementia. A care plan, dated 6/25/12, included, but was not limited to, "Problem Start Date: 6/25/12... Resident [#22] is receiving hemodialysis... at risk for complications such as fluid imbalance, bleeding to left arm shunt... Goal: Resident [#22] will have no complications related to hemodialysis... Approach [start date of 6/25/12]: Assess dialysis access site every shift for excessive bleeding, drainage, swelling, redness, bruit/thrill. Document findings, report abnormalities to MD and dialysis..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A "Dialysis Resident Checklist" dated July 2012, included a checklist for documenting the bruit and thrill for each shift. The following dates were not marked as being documented for bruit and thrill: July 1: days and evenings July 2: days and evenings July 3: days and evenings July 4: nights, days, and evenings July 5: days and evenings July 6: nights, days, and evenings July 7: days and evenings July 8: days July 9: days July 10: days and evenings July 11: nights, days, and evenings July 12: days and evenings Resident #22 was admitted to an area hospital on 7/13/12 and returned to the facility on 7/17/12. There was no other documentation of bruit/thrill assessment for the dates of 7/17/12 through 8/10/12. On 8/10/10 at 10:00 A.M., in an interview, the Director of Nursing indicated there was no other documentation to provide regarding assessment of bruit/thrill for Resident #22.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	C.1. The clinical record of Resident #41 was reviewed on 8/9/12, at 3:00 P.M. Resident #41 was admitted to the facility on 9/22/11. Diagnoses included, but were not limited to, chronic kidney disease, lymphedema, osteoporosis, hypothyroidism, vitamin B deficiency, hyperlipidemia, and hypertension. Physician orders for Resident #41 included, but were not limited to, "Dialysis. . .on Tuesdays, Thursdays, and Saturdays. . ." and "Daily Weights dx [Diagnosis] Dialysis." Daily weight was not documented for the following dates: 5/1/12, 5/4/12, 5/12/12, 5/13/12, 5/14/12, 5/21/12, 5/22/12, 5/29/12, 5/30/12, 6/10/12, 6/23/12, 6/24/12, 6/28/12, 7/1/12, 7/2/12, 7/12/12, 7/13/12, 7/15/12, 7/16/12, 7/17/12, 7/18/12, 7/25/12, 7/27/12, and 7/30/12. 3.1-50(a)(1) 3.1-50(a)(2)			